PRESCRIPTIONS for PROGRESS

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EDITORIAL

How Prepared Are States for MMA?

MORRIS

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In the last issue of *Prescriptions for Progress* we gave an overview of the impact of the pending changes in prescription benefits for people who are eligible for both Medicare and Medicaid (occasioned by the passage of the Medicare Prescription Drug and Modernization Act of 2003, known by the shorthand designation "MMA"). Given the complexity of treatment plans for many people who are disabled because of mental illnesses, we have a special concern about states' readiness to help patients and consumers whose medication regimes may be affected on January 1, 2006.

Late last year, the National Association of State Mental Health Directors Research Institute (NRI) conducted a survey of the state mental health authorities concerning their planning efforts around MMA. Most of the states surveyed reported some planning activities, some states were in the early stages of preparation for the states' response, and almost all were waiting for further clarification from the Centers for Medicare and Medicaid Services. Given the scope of the changes coming in January, 2006—and the fact that the regulations governing MMA 2003 have been released since that initial survey was conducted—we thought it useful to revisit this topic.

Prescriptions for Progress asked Chris Koyanagi, Policy Director for the Bazelon Center for Mental Health Law, to conduct a new survey of state mental health authorities. She also sent the surveys to state mental health offices of consumer affairs so that we could get a read on what efforts were being undertaken from the consumer perspective. We are grateful for the support and cooperation of Dr Robert Glover, Executive Director of the National Association of State Mental Health Program Directors (NASMHPD), for his support and cooperation in the survey process. This newsletter is devoted to the results of that survey. Ms Koyanagi and her colleague, Elaine Alfano, worked tirelessly and on a very brief timeline to conduct the survey, analyze the results, and provide us with this thoughtful overview.

The report clearly shows that state mental health leaders are thinking about MMA and proposing creative strategies. In most states both the Medicaid authority and the mental health authority have cooperative planning efforts under way. However, in many states this isn't the case and the clock is ticking. Given the numbers of people to be impacted and the complexity of the new benefit design, we are especially concerned about the limited attention to outreach to consumers that the survey results reflect. A relative lack of involvement in preparations for MMA is reported by consumer affairs offices in most mental health authorities.

Also in this issue is a perspective from Dr Glover and his colleague Andrew D.

A NOTE TO OUR READERS:

Thanks to the many who have communicated with us about this new publication. Your responses have been truly gratifying to us, and your ideas for future issues are terrific. All of the partners in this effort (Comprehensive NeuroScience, Inc, McGraw-Hill Healthcare and Eli Lilly and Company) are encouraged by your feedback. Nothing warms the heart of an editor more than discovering that people are not only reading a publication, but using it and sharing it with colleagues!

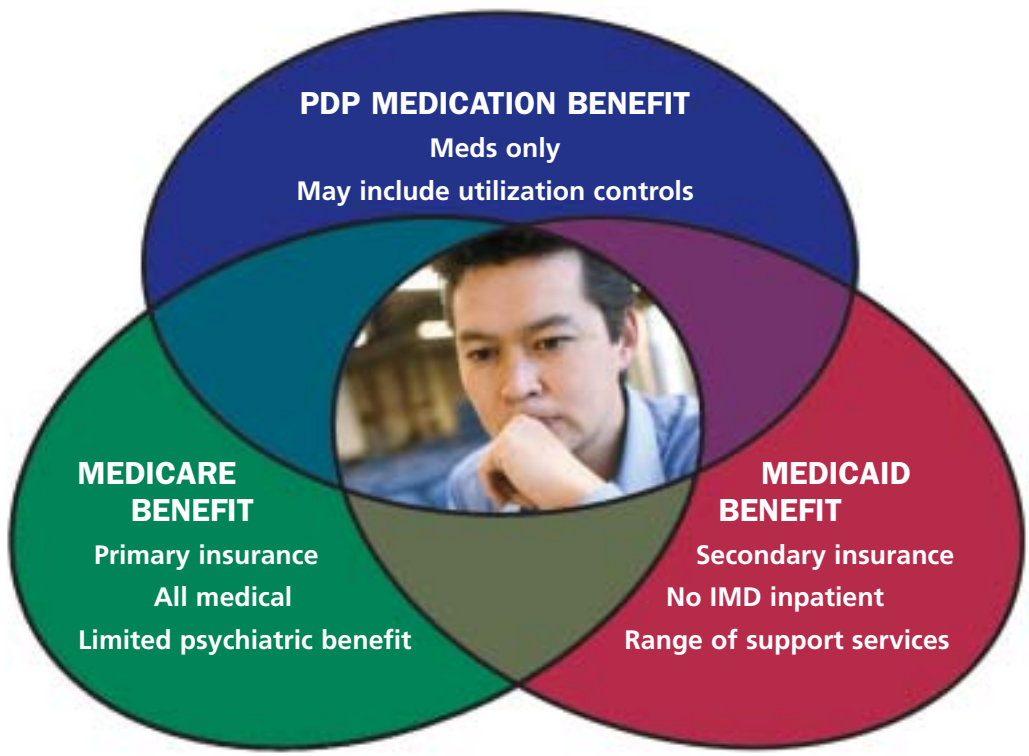
Because of your overwhelming interest in *Prescriptions for Progress*, issues are now posted on McGraw-Hill's *Postgraduate Medicine* Web site, www.postgradmed.com. We will work very hard to maintain the highest standards of writing and content. As always, feel free to communicate with John Morris at jmorris@cnsmail.com.

Hyman, JD, NASMHPD Policy Director. Bob has served as NASMHPD's CEO since 1993 and has a long and distinguished career in mental health administration, having served as a director in several states. Andy has been NASMHPD's policy director since 2001 and before that served as the Director of Intergovernmental Affairs for Secretary Donna Shalala at the Department of Health and Human Services. NASMHPD's energies were initially directed at shaping the regulations that will govern MMA, and now that focus is shifting into providing assistance to the states in preparing for the changes.

Also note in this issue a brief overview of remarks made by Center for Medicare and Medicaid Services Administrator Dr Mark McLellan to the National Governors' Association (accessed at http://www.cms.hhs.gov/media/press/release.asp?counter=1440, on 5/5/05) in which he devotes special attention to concerns about persons who are dually eligible for both Medicare and Medicaid. In this issue we have highlighted several sections from Dr McLellan's address, but one quote will serve as an incentive to read further: "We're implementing (the process of reviewing proposed formularies) now, with multiple checks on each submitted formulary against commonly-used formularies, the drugs actually used by beneficiaries including dual eligibles, and broadly accepted practice guidelines, among other checks. To give you an example, we have made clear that we expect plans to cover all or substantially all drugs for HIV/AIDS, mental illnesses, immunosuppression, and other diseases where a specific medication or combination of medication could be expected to make a real difference for a patient, and where transitions can be clinically difficult." Access and read the full story for more details.

Because of the special vulnerabilities of people who are disabled by virtue of mental illnesses, and because of the pivotal role that medications can play in a successful recovery plan, we will continue to focus on MMA and strategies that can ensure a smooth transition to the new world coming next year.

THE PERSON IN THE PUZZLE



MMA SURVEY OF THE STATES

Ready or Not, Here Comes Part D!

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Introduction

The largest expansion to Medicare since its inception will go into effect in January 2006, accompanied by a significant change in Medicaid prescription drug coverage for those dually eligible for Medicare and Medicaid. Under Title I of the Medicare Prescription Drug, Improvement and Modernization Act (MMA), an estimated 43 million individuals on Medicare will have coverage for prescription drugs for the first time. This is potentially of great benefit to those who currently have no such coverage, particularly uninsured individuals with serious health conditions, such as serious mental illness (see box). However, there are approximately 6 million low-income individuals dually eligible for Medicare and Medicaid who must switch their prescription drug coverage from Medicaid to a Medicare Part D ("Part D") plan.

It is critical that consumers with serious mental illness be educated about the new program, provided with assistance to ensure they obtain the best possible coverage, and protected from the gaps that may arise in their coverage as a result of various provisions in the law. This shift in the public sector healthcare structure will require a coordinated effort at the local level to ensure that risks for individuals with serious mental illnesses are minimized.

To understand how Part D implementation is proceeding in the states, the Bazelon Center for Mental Health Law conducted a mail survey in March and April of 2005. Surveys were sent to state mental health authorities (SMHAs) in all states and the District of Columbia and to the Consumer Affairs Offices (CAOs) that exist within 38 SMHAs. The survey was short and simple, with mostly yes/no questions. The goal was to get a snapshot of state preparations and to identify promising approaches for consumer assistance.

Responses were received from 37 SMHAs (73% response rate) and 22 CAOs (58% response rate). The SMHA survey covered issues related to SMHA planning, consumer outreach and consumer assistance, coverage of medications not covered by Part D plans, cost-sharing assistance for consumers, training and education of front-line staff, and evaluation of the impact of Part D on other state costs. The CAO survey asked about engagement in state-level planning, consumer knowledge of Part D issues, and consumer assistance activities planned by the CAOs.

Findings

While most states seemed to be in the early stages of their planning, this study found that a number of states had, nevertheless, made some important decisions regarding the issues covered in the survey. Overall, this study found:

- SMHAs are consistently at the table with the Medicaid agency in the planning for Part D.
- States are in the formative stages of planning and still seem to be assessing both the impact of the law and how best to proceed.
- Stakeholder groups—consumers and advocates particularly—often have not been included in the planning group.
- CAOs, where they exist, have generally not been part of the planning process either.
- States intend to rely heavily on the current system for helping consumers—ie, local providers, working through their case managers, are expected to provide Part D consumer assistance.
- Consumers are not well informed about Part D. While there is a broad range of ideas for consumer outreach across states, most states indicate that they will rely on only some of these approaches.
- A few states plan to rely on generic consumer education and assistance provided by the federal government, but most of them expect to supplement these efforts.

One study found prescription drug spending by individuals with certain serious health conditions, including a group with mental illness, was 42%-61% higher than spending by all Medicare beneficiaries.

The Department of Mental Health (DMH) is working with the California Mental Health Directors Association to establish a work group that will focus on identifying resources needed by individual counties and has started discussions with the Client Family Member Task Force. DMH has provided an extensive stakeholder list to the Medicaid agency that includes broad representation of providers, consumers, and advocates. DMH is requesting direct training from CMS in a "train the trainers forum" for state staff and staff of regional mental health plans.

- Training for local providers is planned, although many will rely on written materials or workshops and will not provide intensive training.
- Very few states have reached a decision about whether to provide consumers with coverage for medications not covered under Part D, and whether to assist consumers who have problems meeting the cost-sharing requirements.
- Very few states said they would track consumer outcomes or evaluate the impact of Part D on the use of other state services, such as emergency care.

Planning

Background: In spite of the new Medicare benefit, state Medicaid agencies continue to have significant responsibility under the new law, as does the federal Centers for Medicare and Medicaid Services (CMS). CMS will approve Part D formularies (by June) and plans (by September); establish a process to automatically enroll dually-eligible individuals in the fall; and produce materials and activities to inform beneficiaries. CMS is also working with state Medicaid agencies on implementation, including data set exchanges to identify dual-eligible individuals. However, in these broad planning initiatives, the needs of sub-populations with special needs, such as individuals with serious mental illness, can easily be overlooked. Concerns about coordination of care remain, and at present there is no requirement for the Prescription Drug Plans (PDPs) to share utilization data with state Medicaid authorities—data that might indicate that vulnerable individuals had changed medications or discontinued medications essential to their recovery, for example. As much of healthcare moves toward coordinated disease management strategies—in which data sharing and coordination are key—this will bear close watch.

Findings: While SMHAs are involved with their Medicaid agency in Part D planning, consumer affairs offices, as well as individual consumers and advocates, have not generally been included in state planning groups. Many states seem to be in the early stages of planning, apparently still evaluating the implications of the law and an overall course of action. States are challenged by the tight implementation time frames and the significant obligations imposed by the law.

All but a couple of the SMHAs reported that they are engaged with the Medicaid agency and are, to varying degrees, working collaboratively on Part D planning. While 84% of SMHAs reported that there is a specific working group meeting regularly, a smaller percentage (68%) indicated that their working group involved an array of stakeholders. However, some states mentioned that, in the future, they plan to expand stakeholder representation to include providers, consumers, and advocates.

In the states where more expansive groups exist, community provider agencies have been brought into the planning. Consumers, advocates, professional associations, ombudsman programs and managed care entities were less frequently cited when SMHAs described the composition of their state's working group. In addition to Medicaid and the SMHA, other state agencies involved (in one or more states) include mental retardation/developmental disabilities, aging, substance abuse, and the office responsible for senior prescription drug assistance.

While several state agencies may comprise a working group, it appears rare for a consumer affairs office to be included in these important state-level planning groups. Only 23% of survey respondents (5 offices) reported participating in a working group. However, 41% (9 offices) were reaching out to get input from individual consumers about planning for the transition to Part D, and 6 offices (27%) reported that they were working with organized consumer groups in their state.

In terms of activities, these state-level Part D planning groups are focusing on a number of issues including:

- Designing a mechanism to identify consumers with serious mental illness who are dually eligible, with a view to targeting information and assistance to them and providing lists to local providers;
- Determining the information that should be provided to consumers and the means to distribute it;
- Methods to be used to assist consumers in making appropriate decisions on Part D;
- Determining the roles of the SMHA, counties (in county-based systems), and

local providers in implementation of Part D;
- Part D's effect on state pharmacy assistance programs, where they exist; and
- The role of pharmacies.

Consumer Knowledge

Background: It is important for consumers—particularly dual eligibles who will lose their Medicaid coverage—to understand Part D, including how and when that change will happen, and that there will be a system of assistance to help them through the transition.

Findings: Consumers are generally not yet well-informed.

Several questions to CAOs were designed to elicit perceptions about consumers' current knowledge of Part D. The responses to these questions were quite consistent and indicate that CAOs do not believe consumers in their state are aware of, or understand, the changes that Part D will bring. While a sizeable percentage of CAOs, 59% (13), thinks that consumer organizations are not aware that pharmacy coverage for dual eligibles will switch from Medicaid to a Part D plan, an even greater percentage, 77% (17), believes that individual consumers either do not understand this "very well" or understand it "not at all." Generally, survey respondents thought the typical consumer was either "not very knowledgeable" (defined as vaguely aware) or "confused" about Part D.

CAOs generally indicated that they also had insufficient knowledge of Part D. Only 27% felt that they were very knowledgeable, while 69% felt that they did not have enough information on Part D's impact on consumers.

Outreach

Background: The federal government will notify dual-eligible individuals directly (by mail), explaining what they must do to participate in Part D. CMS will offer support through its 1-800-MEDICARE line, post information on a Web page, and run a national advertising campaign. In addition, CMS is providing resources to the State Health Insurance Assistance Programs (SHIPs) for one-on-one advice and counseling. It will also use its 10 regional offices to conduct educational campaigns, to do outreach to low-income individuals, and disseminate culturally and linguistically appropriate information.

However, specialized additional outreach may be needed for consumers with serious mental illness who may not be able to obtain all the information they need from the sources in place for the general population. Given the apparently low level of knowledge among consumers with serious mental illness, it is clear that outreach and education efforts will need to be intensive over the summer and early fall.

Findings: States intend to rely heavily on local provider agencies and case managers to help consumers. While some mentioned informational consumer forums, many states plan to depend primarily on written materials. Most states indicated that they will have supplemental efforts, rather than solely relying on the generic consumer education and assistance programs of the federal government. While collectively states have a broad range of ideas for consumer outreach, most states apparently are not thinking of pursuing all approaches.

Sixty-eight percent of SMHAs (25) report having an outreach strategy to reach dual-eligible consumers. Several others report that outreach would be the responsibility of local providers or community services boards. However, the initiatives are in a nascent stage, even among states with a defined strategy. Most states report upon their intent to have an outreach plan, rather than on the actual plan itself.

In order to conduct targeted outreach, a state must be able to identify those who will be affected by Part D. Medicaid agencies are working with SMHAs to identify dual-eligible consumers, and a few states report that they have the capacity to identify other Medicare-eligible consumers in the public mental health system.

SMHAs were asked if they had specific plans to: 1) ensure that consumers are enrolled in an appropriate plan and that they have the information they need to make an informed choice; and 2) assist consumers who may encounter formulary problems once they are enrolled. Only about half the SMHAs appear to have focused on this level of specificity for consumer assistance, and those states are evenly split between those that will provide this assistance and those that will not. Clearly, a sizeable number of states still have some important decisions to make.

Arizona reports it will include information on Part D issues in member handbooks (for the statewide managed care system), newsletters, and direct mailings. It will ensure that the changes are explained during case management appointments and will provide advocacy groups with information and training so they can assist consumers.

Arizona reports that it will have the capacity to track Part D dual eligibles in order to determine whether or not they are enrolled in a plan, to inform them of the importance of enrolling if they have opted out, and to generally assist them in the enrollment process.

GLOSSARY TERM

Bazelon Center: The Judge David L. Bazelon Center for Mental Health Law is the nation's leading civil rights organization representing people with mental illnesses or mental retardation. Policy Director Chris Koyanagi and Policy Analyst Elaine Alfano conducted the survey reported on in this issue.

- Nineteen states (51%) have plans to ensure consumers sign up or, if automatically enrolled, to ensure they do not then opt out altogether, while 18 do not have any plans at this point.
- Eighteen states (49%) will assist consumers with any future formulary problems (if medication is dropped, for example), while as many as 13 states are undecided about this issue.

Consumer offices were asked about forums that were planned, or have occurred already, to educate consumers on Part D. Thirty-six percent (8) reported that forums/events had occurred or were planned. These included education sessions at statewide consumer conferences, consumer roundtables, presentations at drop-in centers and other sites, information-sharing at the state planning council level, and work with legal advocacy groups in the state. One state that had already held a forum was Alabama (see box below). The level of confusion among consumers at this forum (a few apparently expressed a desire to stay on Medicaid and take a pass on Part D even after it was explained that this is not an option) is an indication of how the complex rules around Part D may confuse those who need to use it. Alabama's experience illustrates the need for face-to-face forums that can help dispel misconceptions and alleviate consumers' uncertainty about whether they will lose access to their medications. These forums can be a useful supplement to other educational efforts that may include mail, phone, and Web-based communications.

At a statewide consumer conference with about 750 consumers in attendance, the state of Alabama organized a workshop on medication issues with a focus on Part D. The session was run by the department pharmacist. Topics included encouraging consumers to take control and self-manage their medications, to be aware of their drug coverage, and to ask their physicians questions about their medications.

Information on the various public plans for access to medications was presented, including information on the indigent drug program, patient assistance programs, Medicaid rules, and Part D. Only about half of the consumers who attended were aware of Part D and the upcoming change. The Part D presentation focused on explaining that there would be changes to how consumers get their medications and that the state would put processes in place to protect and help them.

Consumers in the group were informed that they would soon hear about Part D through mail-outs and other sources and that all Medicare beneficiaries would be eligible to participate in a prescription drug plan. As the process was more fully explained, particularly the elimination of Medicaid drug coverage for dual eligibles, many consumers became quite anxious. However, further information on how the state will assist consumers and ensure that they continue to receive assistance with medications generally reassured the group.

Given the need for broad information-sharing strategies, the range of ideas reported by SMHAs for reaching consumers is encouragingly broad. However, at the time of the survey and with only a few exceptions, states generally reported that they intended to use only 1 or 2 of these strategies. Possibly, states will adopt additional strategies as they refine their plans.

A handful of states reported that they planned to rely on more general outreach materials and activities, such as CMS' Medicare handbook, Web-based materials, and other assistance for the general population. Since CMS is responsible for the outreach and marketing of Part D, one state commented that it was waiting for CMS guidance regarding outreach and suggestions for the state.

Outreach strategies were reported by responding states (see box on page 7).

Working With Providers

Background: There is evidence that lack of coverage (or high cost-sharing) results in individuals failing to take prescribed medications.[1] It is therefore important that consumers choose a plan that will cover most, if not all, of their medications. Since individuals with serious mental illness often require more than one psychiatric medication, as well as other medications for physical health disorders, their decisions concerning choice of plan may be difficult and must be individualized. When a consumer's medication is not on the formulary, professional advice will be needed regarding the possibility of switching to another medication. Local providers are in the best position to help consumers with these issues.

Findings: Across all states and all questions related to outreach strategies, SMHAs indicated that they will rely most heavily on local providers and case managers to reach out to consumers. Training will be furnished, although many states intend to depend on written materials or workshops and will not provide intensive training.

Seventy percent of SMHAs (26) plan to train providers in the intricacies of the Part D benefit, while only 27% (10 states) responded they would not. Almost all states (89%, 33 SMHAs) reported they will provide information to case managers, advocates, providers, and others to help them assist consumers in making informed decisions.

OUTREACH STRATEGIES

DIRECT OUTREACH TO CONSUMER/STAKEHOLDER GROUPS

- Hotline
- Open houses
- Brochures and other materials
- Direct mail of information
- Electronic mail (email and list-serves)
- Information distributed through drop-in centers
- Presentations to consumer and family groups
- Education forums for consumers and families
- One-on-one and group training sessions
- Regional outreach sessions for consumers
- Information to senior citizen groups for outreach
- Member handbook
- Newsletter
- Outreach through state's indigent medication program
- Dedicated staff to assist consumers
- Distribution of CMS materials, adapted for people with mental illness
- Use of CMS materials: Medicare handbook, etc.
- Relying on CMS on-line formulary comparison

OUTREACH THROUGH PROVIDERS

- Training case managers
- Training local provider agencies' staff
- Training benefits staff
- Materials and/or training for psychiatrists
- Materials or other outreach to pharmacies
- In-service staff training through the Social Security Administration

GLOSSARY TERM

MA-PD, MA-PD SN: Medicare Advantage Prescription Drug Plans, also Medicare Advantage Special Needs Plans, are set up to serve a greater number of beneficiaries who have some special needs, such as serious and persistent mental illnesses.

States generally expect that the provision of training and information to local providers or mental health plans will result in individualized approaches to consumer communications and problem-solving. Although states were only reporting on what they currently expect to do, it seems the burden of responsibility for assisting consumers will fall on local agencies. While the dependence on providers seems like it will be widespread, it appears that the degree of support and training for these local providers will vary across states.

The heavy reliance on case managers raises some important concerns. Due to chronic under-funding of public mental health, made worse by state budget crises in recent years, case managers have been poorly paid and burdened with large caseloads. As a result, there is a high turnover rate and relatively inexperienced staff in these positions. Thus this strategy, if used as the primary means to assist consumers with decisions on medication coverage under Part D, is potentially fraught with problems. Very careful training of case managers will be needed to ensure that they can help consumers understand their best option under Part D, and yet it is widely recognized that states have significantly reduced training capacity. If consumers have questions involving specific medications, case managers would likely need to bring in individuals with medical expertise—a high-cost resource not universally available for non-billable time.

Covering Medications/ Costs Not Covered Under Part D

Background: Part D plans are not expected to have coverage that equals that of state Medicaid programs. Rules require that plans include 2 unique drugs in each therapeutic class or category, and generally their formularies are expected to be consistent with United States Pharmacopeia (USP) model guidelines. While plans are allowed to charge higher co-payments for certain non-preferred drugs, they must have a process for addressing the need of some enrollees to have access to drugs that are not on the formulary. The law allows for changes to formularies at the beginning of every plan year.

Findings: Very few states have made the decision to provide consumers with coverage for medications not covered under Part D, or to assist consumers who have problems meeting cost-sharing requirements. Most states have not yet made final decisions on these issues.

While there are potentially a number of ways in which a consumer on Medicare

GLOSSARY TERM

MMA: The Medicare Prescription Drug and Modernization Act of 2003. This legislation creates a new Medicare pharmacy benefit for people who are dually eligible for Medicare and Medicaid.

GLOSSARY TERM

SMHA: The State Mental Health Authority, a federal designation for the agency that is charged with implementing mental health programs for the state; the SMHA is the agency for the state through which federal block grant dollars flow. In some states, the SMHA also has authority over substance abuse disorders treatment or services to people with developmental disabilities.

might be left without appropriate medication coverage, despite having signed up for the plan offering the best option, SMHAs reported they have generally not yet resolved how to deal with these issues. SMHAs were asked whether they would assist consumers with specific potential problem areas. Only 8 states can currently assert that the SMHA will assist consumers with even one of these difficulties and only 3 (Oklahoma, Rhode Island, and Texas) reported that the SMHA has affirmatively decided to assist consumers in all 3 areas. The questions, and SMHA answers, are tabulated in the table on page 9.

As the table indicates, many states have some very significant decisions that have not yet been made.

Under the federal statute, Part D plans will not cover benzodiazapines and certain other medications. These medications can, however, remain covered for Part D dual eligibles through the state's Medicaid program. SMHAs were asked whether their state would cover benzodiazapines, either through the SMHA or through continued or expanded Medicaid coverage. Twelve states (32%) indicated that they would provide coverage. Fifty-nine percent (22 SMHAs) reported that the decision was still pending. Two SMHAs responded that the state had decided not to pay for benzodiazapines.

SMHAs were also asked to indicate the revenue source that would pay for medications not covered through a Part D plan.

- Six states indicated resources would come from both the SMHA (general revenue) and state-only Medicaid funds.
- Four states indicated resources would come from the SMHA only.
- Two states indicated state Medicaid funds would be the only source of funding.
- Six states indicated other resources (state special revenue, patient assistance programs, and local property taxes).

Assistance to Those Not Dually Eligible

Background: While there is much focus on the dually-eligible Part D consumers, there are individuals with serious mental illness on Medicare who are not covered by Medicaid. These individuals currently have no prescription drug coverage and can be expected to benefit significantly under Part D. One model of drug spending under Part D projects that people with mental illnesses who currently have no drug coverage will need to spend $3,594 a year for prescription medications under Part D. The data suggest that Part D will enable these individuals to increase their spending on necessary medications by 61% and will also reduce their out-of-pocket costs modestly (16%).[2]

On the other hand, the MMA creates a "donut hole" for these individuals where there is no coverage for prescription drugs. Under the new regulations, this occurs when an individual's drug purchases reach $2,250 in the benefit year (non-formulary drugs are excluded from the cumulative tally of drug spending) and continues until drug expenses reach $3,600. Thus in this window where there is no coverage, individuals must pay entirely out-of-pocket. The model cited above found that the average beneficiary with mental illness will fall into the donut hole in 2006, but will not spend their way out of it—the gap between the beginning of the donut hole and the expected average spending of $3594.00.[2]

Findings: States are focusing more on the population that is dually eligible, but many intend to reach out to other Medicare beneficiaries as well, generally using the same methods and approaches as for dual eligibles.

Sixty-two percent of SMHAs (23 states) responded that they would include consumers with Medicare-only coverage in their outreach and education efforts. Generally, states indicated that outreach and education for this group would be the same as for dual eligibles.

When asked whether the state will be able to provide access to medications for those consumers who fall into the donut hole, only 8% (3 states—Oklahoma, Vermont, and Virginia) indicated that they would. The majority of states (31) reported no decision, with only 1 state indicating that it had decided not to provide coverage.

Of the 19 states that had a pharmacy assistance program providing drug coverage to these other Medicare beneficiaries, 13 indicated that the state planned to transfer those consumers into Part D. All but 1 of these indicated that the SMHA is participating in the planning for the transfer.

SMHA PROVISIONS

QUESTION	YES	NO	NOT YET RESOLVED
Will the SMHA provide medications for consumers whose drug plans do not cover the medication they are now on?	7	4	26
Will the SMHA provide medications for consumers for whom the treating physician recommends an uncovered medication in the future?	4	5	28
Will the SMHA provide assistance to consumers to meet the out-of-pocket costs for medications off the formulary?	4	6	27

Access to Medications for Physical Disorders

Background: Numerous studies over the last 30 years have found high rates of physical health-related problems and premature death among individuals with serious mental illness.[3] Access to a range of non-psychiatric medications is therefore important for these individuals.

Findings: The serious physical health problems of many patients with mental illness further complicate decisions regarding choice of plan, since it may be difficult to find a plan that provides access to all the specific medications a particular individual requires. Most states, however, have not yet addressed this potential problem.

SMHAs were asked whether any state agency would provide access to appropriate medications to treat physical health problems of people with serious mental illness if they cannot access those medications through their Part D plan. Only 4 states were sure that this would occur (District of Columbia, Missouri, Oklahoma, and Pennsylvania); 5 stated it would not. Twenty-seven states (73%) reported that the issue was unresolved.

Tracking Implementation

Background: Given the great uncertainties about how Medicaid-eligible consumers with serious mental illness may fare under the Part D program, states may wish to track implementation. Prior research indicates that when consumers do not have ready access to appropriate medication, spending on emergency and inpatient services can increase.[4]

Findings: Very few states have any plans to track the outcome for consumers or evaluate the impact of these changes on the use of other state services, such as emergency care. SMHAs were asked whether they intended to conduct (or contract for) an evaluation of the impact of Part D on increased service utilization and costs. To date, only 3 states (Arizona, Missouri, and Montana) have decided to do this, while 78% (29 states) did not report a decision. The complexities of tracking the impact are considerable, not least of which is the lack of a data sharing requirement for the PDPs.

Conclusion

Findings from this study suggest that, at the time of this survey, many states were in the very earliest stages of planning for the transfer of individuals with serious mental illness into Part D drug plans. While few states yet had fully comprehensive approaches in mind, this picture may change over the summer. At the same time, a number of promising strategies were reportedly planned by 1 or more states. If all these potentially important and helpful strategies were to be adopted in a comprehensive and coordinated way by any 1 state, consumers could be protected from substantial harm. These strategies include:

- Identify consumers—dually eligible and Medicare only—who are affected.
- Ensure that consumers, families, and advocates (including representatives from consumer affairs offices, consumer organizations, and ombudsman programs), providers (including representatives from mental health and health provider agencies) and

GLOSSARY TERM

PDP: Prescription Drug Plans are the companies that will manage the pharmacy benefit. Each service area defined by the Centers for Medicare and Medicaid Services must offer a choice of at least 2 prescription drug plans to consumers.

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pharmacists are represented on all important planning groups.
- Prepare informational materials for consumers, families, and advocates, targeted to issues of concern for consumers with mental illness covering both Part D and state programs providing access to medications.
- Design an educational campaign, with an emphasis on face-to-face contact and repeated opportunities for consumers to ask questions and learn about Part D.
- Have state consumer benefits specialists available (for example, through a toll-free number) to answer consumer and provider questions about Part D and state assistance programs.
- Set up a system for training all relevant providers—public agency staff (including nurses and physicians as well as case managers), privately practicing psychiatrists and other professionals.
- Encourage CMHCs to work with community health centers on all issues related to access to medications for consumers with mental and physical health conditions.
- Review Part D, identify potential gaps in coverage for consumers (including those resulting from formularies and co-payment requirements), and put policies in place to ensure consumers have access to necessary medications.
- Ensure that medications that cannot be covered under Part D (such as benzodiazapines) are covered either by Medicaid or the SMHA.
- Track the impact of Part D implementation on consumers with serious mental illness.

As consumers begin to get information on Part D from CMS, state Medicaid agencies and other groups will likely follow suit, offering additional informational materials and assistance. Consumers with serious mental illness could well be alarmed or overwhelmed by a multitude of different initiatives. Unless state mental health systems are able to provide reassurance that there will be policies in place to protect access to psychiatric medications, and are able to help consumers sort through their options under Part D coverage, it is quite likely that there will be a great deal of confusion and concern. Ready or not, Part D implementation is proceeding at a rapid pace. Over the course of this transition, state mental health authorities and consumer affairs offices may find themselves stretched to their limit as they try to help consumers navigate uncharted waters.

COMMENTARY

NASMHPD Perspective on the MMA Survey

GLOVER

Robert W. Glover, PhD, Executive Director, National Association of State Mental Health Program Directors (NASMHPD)

HYMAN

Andrew D. Hyman, JD, Policy Director, NASMHPD

THERE IS MUCH WE CAN LEARN FROM THE BAZELON CENTER FOR Mental Health Law's survey assessing state mental health agencies' efforts to implement the Medicare Prescription Drug and Modernization Act of 2003 (MMA). But perhaps the most important aspect of the survey is its impeccable timing. It neither points fingers nor laments what might have been; rather it looks forward, endeavoring to encourage and guide states' activities in order to minimize the harm that could come to the millions of people served in the state public mental health systems when the MMA goes into effect.

Seven months remain before the MMA kicks in and Medicare begins providing coverage for a voluntary, outpatient prescription drug benefit, established as "Part D" of the Medicare program. For millions of people who are or will be eligible for Medicare and who do not have access to insurance coverage for prescription drugs or for whom their existing coverage represents a great financial burden, the

MMA and this new benefit may be most welcome. But for the approximately 6.4 million dual eligibles (those enrolled in both Medicare and Medicaid), implementation of the law is considerably more complex and poses some risk.

On January 1, 2006, Medicaid prescription drug coverage will terminate for dual-eligible beneficiaries, and they will begin receiving their coverage through private entities that contract with the Center for Medicare and Medicaid Services (CMS), including either stand-alone prescription drug plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs), which are managed care plans that cover all Medicare benefits, including drugs. At the same time, dual eligibles (as well as other categories of low-income beneficiaries) will qualify for subsidies that will offer substantial assistance in paying the Part D premium and cost sharing associated with drug coverage.

The conversion from Medicaid to Medicare Part D creates 2 types of problems for dual eligibles. The first relates to the challenge of enrolling millions of beneficiaries into these new and untested private plans. The second is the possibility that beneficiaries—even if the transition succeeds—may be placed in plans that do not cover the drugs they need. Of course, the risks posed by both of these outcomes are heightened for people with mental illness or cognitive impairments, who make up nearly 40% of the dual-eligible population—or 2.5 million people. We should anticipate that many of them will be unable to navigate the transition process easily, may lack the capacity to select a plan that is appropriate to their needs without assistance, and may not have a clear understanding of what to do if they are denied coverage for a drug that has been prescribed (and has worked) for them in the past.

The first problem is largely logistical: How do we ensure that beneficiaries do not experience any gap in coverage? In theory, there should be no such gap. Under the MMA and its implementing regulations, dual eligibles will be auto-enrolled starting in the Fall; unless they change their plan, their new coverage begins January 1, 2006—whether it is the best plan for them or not. Similarly, dual eligibles are automatically enrolled in the low-income subsidy, a process that is managed by the Social Security System. However, the success of these processes will depend on perfect completion of numerous steps, each of which is highly complex and vulnerable to human and computer error: compiling by every state Medicaid agency complete and accurate lists of their dual eligible beneficiaries; electronically transferring that data—6.4 million names—to CMS; matching those beneficiaries to the appropriate plans; and communicating the matches to the plans, the beneficiaries, and the pharmacies. As pointed out by the Medicare Rights Center, even a 90% success rate would leave more than 640,000 dual eligibles without prescription drug coverage following the transition date.

The second problem stems from the possibility that even if the beneficiary is enrolled seamlessly into the new Part D plan, the new plan's coverage may be less comprehensive than that offered under Medicaid and may not include coverage of all the beneficiary's current drug therapies. Prescription drug coverage is an optional Medicaid benefit; however, all states include it in their plans. In addition, once a state chooses to provide drug coverage, the benefit contains numerous federal safeguards, guaranteeing beneficiaries access to a wide array of drugs. Moreover, states have a strong incentive to protect beneficiaries' access to prescription drugs since states' Medicaid plans or other state services (like state hospitals) will bear the burden of more costly medical interventions that would otherwise occur. Although the scope of the drug benefit varies from state to state, mental health advocates have succeeded in defeating many onerous proposals designed to limit access to psychotropic medications. The MMA gives PDPs considerable discretion to use cost management tools, such as formularies, prior authorization, fail first, and step therapy (for explanations of these terms, see *Prescriptions for Progress Vol. 1, No.1*, which is available at www.postgradmed. com), and PDPs will have every incentive to use them and limit access to these drugs—and therefore lower their costs—since they will not be responsible for increased costs if the beneficiary's health status worsens.

CMS has sought to allay the many concerns of state mental health authorities (SMHAs) and the mental health community by providing for automatic enrollment of dual eligibles and by issuing sub-regulatory program requirements that are designed to protect beneficiaries during the transition and ensure coverage of psychotropic medications. For example, PDPs

GLOSSARY TERM

USP: The United States Pharmacopeia Convention, Inc. As described on their Web site, USP "helps to ensure that consumers receive quality medicines by establishing state-of-the-art standards that pharmaceutical manufacturers must meet. As the world's most highly recognized and technologically advanced pharmacopeia, USP provides standards for more than 3,800 medicines, dietary supplements, and other healthcare products." (www.usp.org, accessed 2/3/05).

GLOSSARY TERM

NASMHPD: (Usually pronounced "nash-bid"). The National Association of State Mental Health Program Directors, which is the organization for people who head their state's mental health programs or state mental health authority (see SMHA). Each state structures its mental health program somewhat differently; in some states, the Director or Commissioner is on the governor's cabinet, in others they are part of umbrella health agencies, and in some they report to appointed commissions.

will be required to have an "appropriate transition process" pursuant to which the PDP would permit coverage for a temporary one-time 30-day transition supply of a drug not on its formulary. Other guidance describes CMS' "expectation" that formularies would contain a majority of antidepressants and antipsychotics, and 4 other classes of drugs. And in meetings with SMHAs and other stakeholder groups in the mental health community, CMS officials have given even stronger assurances, stating unequivocally that beneficiaries would have access to the full array of psychiatric medications.

These are certainly welcome steps, but they will not guarantee a smooth transition. We must expect that computer databases will be incomplete; that beneficiaries will not receive correspondence from CMS (or read or understand the correspondence if it is received); that plans (after the 30-day transition) will deny coverage for certain drugs; that beneficiaries will not know what to do if coverage is denied. CMS is well aware of these potential gaps, and is working to partner with the states to conduct outreach and education campaigns to mitigate the risks.

SMHAs will want to play an active role in these efforts. The people they serve and their families and caregivers are the ones at greatest risk in the transition and have the most to gain by being well informed. SMHAs would do well to consider the strategies identified in the Bazelon survey, most of which were culled from states' best practices. But this will not be easy. SMHAs literally have no funding to engage in MMA implementation activities or to design, manage, or participate in statewide outreach campaigns. Although the MMA provides special education grants to states with state pharmacy assistance programs (SPAPs) to educate enrollees about the new Medicare Part D drug benefit, these funds are not aimed specifically at education and outreach for dual eligibles and are not available in the 30 states without an SPAP. Therefore, states will want to conduct a careful needs assessment, prioritize, and act efficiently.

Regardless of what strategies the SMHAs choose to employ, they should take care not to reinvent the wheel. To that end, SMHAs may want to consider the following points.

First, they should begin by learning about their state's education and outreach program—most likely run out of the governor's office or the health or Medicaid agency. They should then incorporate their efforts into and work within the parameters of the statewide plan, allowing the SMHA to make most efficient use of the state's already established infrastructure.

Second, SMHAs should include a discussion of the MMA in virtually any speaking engagement, meeting, or forum in which consumer and family groups, providers, community-based organizations, and advocacy groups are present. In addition, all materials being disseminated to their constituencies in the normal course of business should reference MMA implementation and provide instructions regarding where to get additional information.

Third, SMHAs should find out what resources are already available to states and organizations conducting outreach efforts. For example, every state has a State Health Insurance Assistance Program (SHIP), which operates under grants from CMS to provide free counseling and assistance to Medicare beneficiaries and their families. In May, CMS awarded $31.7 million to SHIPs specifically to enhance their MMA implementation activities.

Fourth, in preparing educational material targeted at consumers and their families, SMHAs should use documents that have already been crafted or approved by CMS for this purpose. This will not only save resources, but also will ensure greater accuracy and consistency in the information they share with stakeholders. A good place to begin is the CMS Web site, which contains helpful outreach and education materials, including an Outreach Toolkit: http://www.cms.hhs.gov/partnerships/tools/materials/medicaretraining/MPDCoutreachkit.asp. The Social Security Administration's Web site is another useful source for outreach material, particularly information pertaining to the low-income subsidy: http://www.socialsecurity.gov/organizations/medicareoutreach2/.

With 7 months remaining until Medicare Part D takes effect, SMHAs still have time to educate their constituencies about the new benefit, how it works and affects them, and the choices they will need to make. Given the extraordinary burdens facing our public mental health systems, this is not an easy task. However, it is certainly more rewarding than the alternative: assessing what went wrong and why?

NGA ADDRESS

Dr McLellan Speaks to Issues of Dual Eligibilty

McLELLAN

Mark B. McLellan, MD, PhD, Administrator of the Centers for Medicare and Medicaid Services

In an address to the National Governors' Association in Chicago late last month, Mark B. McLellan, MD, PhD, administrator of the Centers for Medicare and Medicaid Services (CMS), reflected particular attention on the impact of MMA on those individuals who are dually eligible for Medicare and Medicaid, including a specific reference to individuals with mental illnesses.

Because of the nature of Medicaid as a joint state/federal program, this major change in prescriptions benefits has large financial, clinical, and programmatic implications for the nation's governors. (Readers may wish to see *Prescriptions for Progress, Vol. 1, No. 2* for a detailed overview of MMA 2003.)

The presentation appears to have broken new policy ground as Dr McLellan placed emphasis on including "all" or "substantially all" (p 6) drugs for individuals who have especially complex illnesses—and he explicitly included people with mental illnesses. This reflects a sustained series of clarifications about what can be included of the potential formularies for people with mental illnesses. In the first version of the proposed regulation, it appeared that there would be only a requirement for "2 drugs from each class." This was then widened to reflect inclusion of medications that are reflective of best practice guidelines for "depression, bipolar disorder, and schizophrenia" (A Strategy for Transitioning Dual Eligibles From Medicaid to Medicare, April 25, 2005, accessed on May 9, 2005 at http://www.cms.hhs.gov/medicarereform/strategyforduals.pdf).

He also made it clear that there is a real sense of urgency about getting information to consumers, stating "start as early as possible, and work with as many collaborators as possible."

He further pledged CMS' commitment to work with states to help them get the word out on the changes.

In his comments, Dr McLellan compared benefits under MMA with federal employee health benefits, traditionally regarded as excellent coverage. It will be interesting to see if CMS policy moves to link disability coverage with the federal employee benefit as a benchmark.

Many have expressed concerns about consumers and patients experiencing difficult—and even dangerous—disruptions in their medications, and Dr McLellan outlined a transition strategy that may provide a safety valve for patients: "... states can fill 90-day prescriptions in December and collect the usual Federal match, in effect extending the transition period even further." While this provides an umbrella for consumers, it places a burden on state Medicaid authorities to come up with the state match for this unplanned and unbudgeted expenditure—and actually could result in states absorbing prescription drug costs for 90 days, costs for which the private PDPs are at risk.

In concluding his remarks, Dr McLellan echoed concerns that many of the mental health community share: "Coordination of care and disease management are proven approaches—in conjunction with drug coverage—to reduce costs and improve the quality of the care we provide our dual-eligible beneficiaries, who account for a large share of the costs of both Medicaid and Medicare, and who too often receive poor-quality care."

Our readers are encouraged to visit the CMS Web site (www.cms.hhs.gov) regularly to stay current on changes in MMA as we move toward implementation in just a few months.

TO STAY CURRENT ON MMA...

Visit the Center for Medicare and Medicaid Services Web site **www.cms.hhs.gov** often. There are many useful links and the site will become increasingly active—and valuable—as a conduit for information as we approach the January 1, 2006 implementation date.

STANDARD & POOR'S

What Is a Not-for-Profit Healthcare Rating?

TODAY'S HEALTHCARE SECTOR FACES MANY SERIOUS CHALLENGES. HOSPITALS ARE GRAPPLING WITH SEVERE NURSING shortages, skyrocketing pharmaceutical costs, and day-to-day uncertainties over managed care and regulatory changes. There are financial challenges as well: maintaining positive financial performance, adequate cash balances, and access to capital, while access to credit enhancements is diminished. Then there is disclosure: Investors today are concerned about full disclosure of financial performance.

Standard & Poor's healthcare analysts rate nearly all major US hospitals and health systems—and they rate more than 600 hospitals and senior living organizations nationwide. They also rate just about every type of healthcare provider, including academic medical centers, specialty hospitals, long-term care providers, and human-services providers. For a look at the latest not-for-profit ratings on hospitals and health systems, see the list at right.

WHAT THE "LETTER" RATINGS MEAN

What is a Standard & Poor's rating?

A credit rating is Standard & Poor's opinion on the general creditworthiness of an obligor, or the creditworthiness of issuers of capital market obligations. Over the years credit ratings have achieved wide investor acceptance as convenient tools for differentiating credit quality.

S&P's ratings are based on information provided by the issuer together with other information we consider reliable. Ratings may be changed, suspended, or withdrawn because of changes in or unavailability of information.

A rating does not constitute a recommendation to buy, sell, or hold a particular security. It does not comment on the suitability of an investment for a particular investor. S&P does not perform an audit in connection with any rating.

AAA: Extremely strong capacity to meet financial commitments. Highest rating.

AA: Very strong capacity to meet financial commitments.

A: Strong capacity to meet financial commitments, but somewhat susceptible to adverse economic conditions and changes in circumstances.

BBB: Adequate capacity to meet financial commitments, but more subject to adverse economic conditions

BBB- (minus): this is the lowest rating before non-investment grade.

BB: Less vulnerable in the near-term but faces major ongoing uncertainties to adverse business, financial and economic conditions.

B: More vulnerable to adverse business, financial and economic conditions but currently has the capacity to meet financial commitments.

CCC: Currently vulnerable and dependent on favorable business, financial and economic conditions to meet financial commitments.

CC: Currently highly vulnerable.

C: A bankruptcy petition has been filed or similar action taken but payments or financial commitments are continued.

D: Payment default on financial commitments.

UPDATES

If you'd like to receive regular email updates on Standard & Poor's Healthcare Credit Ratings, send an email to **sarah_demann@mcgraw-hill.com**. Please put *S&P Ratings* in the subject line.

NOT-FOR-PROFIT HEALTHCARE RATINGS ACTIONS, APRIL 2005

Hospitals and Health Systems	State	Rating	Outlook	Action
Banner Health System*	AZ	AA-	Stable	New issue; rating affirmed
BJC HealthCare*	MO	AA	Stable	New issue; rating affirmed
Caritas Christi*	MA	BBB	Stable	Rating affirmed
Central Michigan Community Hospital Mount Pleasant	MI	BBB-	Stable	Rating affirmed and outlook revised to stable from positive
Children's Hospital of Wisconsin	WI	A+	Stable	Rating affirmed
Community General Hospital of Greater Syracuse	NY	BB+	Stable	Rating raised to 'BB+' from 'BB' and outlook is stable
Crittenden Memorial Hospital	AR	BB-	Negative	Rating affirmed
Fairmont General Hospital	WV	BB	Stable	Rating affirmed
Fairview Health Services*	MN	A	Positive	New issue; rating affirmed and outlook revised to positive from stable
Fauquier Hospital	VA	BBB+ (SPUR)	Stable	Rating affirmed
Froedtert and Community Health	WI	AA-	Stable	New issue; rating raised to 'A-' from 'A+' and outlook is stable
Glenwood Regional Medical Center	LA	BBB	Negative	Rating affirmed
Good Samaritan Hospital of Lebanon	PA	BBB+	Stable	Rating affirmed
Grand View Hospital	PA	A- (SPUR)	Stable	Rating affirmed
Great Plains Regional Medical Center	NE	A	Stable	Rating raised to 'A' from 'A-' and outlook is stable
Guthrie Health Care System	PA	A-	Stable	Rating affirmed
Hillsdale Community Health Center	MI	BBB-	Stable	Rating affirmed and outlook revised to stable from positive
Huntington Hospital	NY	BBB	Stable	Rating affirmed
Huntington Memorial Hospital	CA	A+	Stable	New issue
Inova Health System Foundation*	VA	AA+	Stable	New issue; rating affirmed
Jefferson Health System*	PA	AA-	Stable	New issue; rating affirmed
John Muir/Mt. Diablo Health System	CA	A+	Stable	New issue; rating affirmed
Longmont United Hospital	CO	BBB-	Stable	Rating affirmed
Mayo Foundation*	MN	AA	Stable	Rating affirmed
McLeod Regional Medical Center	SC	A (SPUR)	Stable	Rating affirmed
Merle West Medical Center	OR	BBB	Stable	Rating affirmed
Monongalia Health System	WV	A-	Negative	New issue; rating affirmed
Mount Sinai Medical Center	FL	BB+	Stable	Rating raised to 'BB+' from 'BB' and outlook is stable
Newport Hospital	RI	A-	Stable	Rating affirmed
Palmetto Health Alliance*	SC	BBB+	Stable	Rating raised to 'BBB+' from 'BBB' and outlook is stable
Peninsula Regional Medical Center	MD	A	Stable	Rating affirmed
Pinnacle Health System*	PA	A- (SPUR)	Positive	Rating affirmed and outlook revised to positive from stable
Prairie Lakes Health Care System	SD	A-	Stable	Rating raised to 'A-' from 'BBB+' and outlook is stable
Reid Hospital and Health Care Services	IN	AA-	Stable	New issue
Scripps Health*	CA	A	Stable	New issue
Sierra View Local Healthcare District	CA	BBB+	Stable	Rating affirmed
South Georgia Medical Center	GA	A+ (SPUR)	Stable	Rating affirmed
Sparrow Obligated Group	MI	A+	Stable	New issue; rating raised to 'A+' from 'A' and outlook is stable
Spectrum Health	MI	AA	Stable	New issue; rating affirmed
St. Joseph Health Services	RI	BBB-	Stable	Rating affirmed and outlook revised to stable from negative
Sun Health Corp.	AZ	BBB	Stable	New issue; rating affirmed and outlook revised to stable from developing
Sutter Health System*¶	CA	AA-	Stable	Rating affirmed
SynergyHealth Inc.	WI	BBB+	Stable	Rating affirmed
Torrance Memorial Hospital Medical Center	CA	A+	Stable	Rating affirmed
University of Illinois Medical Center	IL	A (SPUR)	Stable	Rating affirmed
University of North Carolina Hospitals at Chapel Hill	NC	AA-	Stable	New issue; rating affirmed
Washington Regional Medical Center	AR	BBB	Stable	Rating raised to 'BBB' from 'BBB-' and outlook is stable

*System. ¶Disclosure Plus client.

IN FUTURE ISSUES...

Number 4:
Because of the critical importance of the changes coming with MMA, we will devote the final issue of Volume I to additional coverage of the new Medicare prescription drug benefit for people who are dually eligible.

TIMELINE FOR DUAL ELIGIBLE ACTIVITIES

2005

MARCH - JUNE: AWARENESS PHASE FOR THE MEDICARE PRESCRIPTION DRUG BENEFIT

MARCH

- 16 – Centers for Medicare and Medicaid Services (CMS) issues transition guidance for Medicare prescription drug plan sponsors (Appendix D).
- States submit first test enrollment files.

APRIL

- 30 – Low-Income Fact Sheet available through www.medicare.gov.

MAY

- Mid-May – CMS mails a notice to full-benefit dual-eligible beneficiaries in 44 states and the District of Columbia notifying them that they automatically qualify for the low-income subsidy and don't need to apply.

JUNE

- Early June – CMS mails a notice to full-benefit dual-eligible beneficiaries in 6 states (IL, FL, SC, WI, VT, and MD) notifying them that they automatically qualify for the low-income subsidy and don't need to apply.

OCTOBER - DECEMBER: ENROLLMENT PHASE OF OUTREACH AND EDUCATION CAMPAIGN

OCTOBER

- Medicare & You handbook mailed to all beneficiaries, with drug plan information.
- Mid-October – CMS assigns full-benefit dual eligibles to prescription drug plans and notifies them of the plan assignment.
- Mid-October – CMS notifies plans of full-benefit dual-eligible enrollees.
- Mid-October – CMS notifies states of the plan assignments of their full-benefit dual-eligible residents.
- Mid-October – Full-benefit dual eligibles begin reviewing their prescription drug plan options and deciding if they want to opt out of their assigned plan.

NOVEMBER

- 1 – Begin routine monthly auto-enrollment and notification for new full-benefit dual eligibles.
- 15 – Enrollment period begins if dual eligibles want to opt-out of their assigned plan.

DECEMBER

- 31 – Full-benefit dual eligibles must opt-out of their assigned plan by this date or they will be auto-enrolled.
- 31 – Medicaid drug coverage ends for full-benefit dual eligibles.

2006

JANUARY - MAY: URGENCY MESSAGE PHASE

JANUARY

- 1 – Medicare prescription drug coverage begins.
- 1 – Prescription drug coverage by auto-enrolled plan effective for full-benefit dual eligibles

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